

305007

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

85 29582

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR			
FIRST MIDDLE LAST <b>JUNE Cecelia ALLEN</b>			MONTH DAY YEAR <b>October 26 1985</b>			6:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR 12-28-34		51 YRS		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				TALBOT MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
EASTON		Memorial Hospital				Waitress			
13a. STATE			13b. CITY OR TOWN		13c. STREET ADDRESS / ZIP CODE		13d. INSIDE CITY LIMITS?		
Maryland			Q.A.		Rt. 1 Box 231-H 21619		YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST Albert Griffin Thomas			FIRST MIDDLE LAST Elsie Cecelia Thomas						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS				
No			218-30-1420		Karen Spurry, P. O. Box 192, Grasonville, MD 21638				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:								4 days	
IMMEDIATE CAUSE (a) <u>Gram negative sepsis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause lost									
(b) <u>urinary tract infection</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>ulcerative infective skin eruption</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1									
<u>GI bleeding (?pharynx), severe hepatic failure, severe rheumatoid</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>10/25</u> 19 <u>85</u> to <u>10/26</u> 19 <u>85</u> , that (I) (we) lost <u>above</u> the deceased and on <u>10/25</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE OF REGISTRAR								22c. DATE SIGNED	
<u>ABRAHAM T. DAWKINS JR.</u>								10/26/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS	
ABRAHAM T. DAWKINS JR.								Route 3, Box 127, EASTON, MARYLAND 21601	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			10-29-85		Stevensville Cemetery		Stevensville Q.A. MD		
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Helfenbein Funeral Home					21619		OCT 30 1985		
Chester, Md.							Davidson-Rendall		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use at the burial-transit permit. Then please remove all information from pages 1 and 2 and return them to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked as item 18, when any injury, or other traumatic event, the medical examiner will make medical investigation.

*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "U.S.A.", "U.S. AIR FORCE", and "OFFICE" are faintly visible.]*



295154

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles L. Lawrence Andrew		2a. DATE OF DEATH MONTH DAY YEAR October 9 1985		2b. HOUR 4:40 M	
1. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR November 30, 1915		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.	
10. CITY OR TOWN OF DEATH EASTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HEALTH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a. USUAL OCCUPATION Cpt. (retired) Md. State Police		12b. KIND OF BUSINESS OR INDUSTRY Law Enforcement
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Queen Anne's	13c. CITY OR TOWN Centreville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Robert Andrew		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mattie Ellen Poole			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-10-7242		17. INFORMANT Wife Mrs. Ethel B. Andrew, Centreville, Md. 21617	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Hepatocellular Carcinoma DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cervical Disc Disease Esophageal Carcinoma					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/19 1985, to 10/9 1985, that (I) (we) last saw the deceased alive on 10/8 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Wm H Wood		DEGREE MD		22c. DATE SIGNED 10/9/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm H Wood		22e. ADDRESS EASTON, Md. 21601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 11, 1985		23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Centreville, Q.A.Co., Md.					
24. FUNERAL DIRECTOR NAME James H. Barton, Jr. 21617 Barton Funeral Home		25a. DATE REC'D. BY REGISTRAR T 15 1985			
25b. REGISTRAR'S SIGNATURE John Barton					

2015

Charles Lawrence

November 20, 1955

Ernest

27-11-1955

27-11-1955



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289104

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 5 8 4

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Delma J. Baynard</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-1-85</b>			2b. HOUR <b>2:13 P</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 31 08</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.			
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital at Easton</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Caroline</b> 13c. CITY OR TOWN <b>Greensboro</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS / ZIP CODE <b>Academy Street 21639</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert E. Jones</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katie Urry</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-20-4652 A</b>		17. INFORMANT ADDRESS <b>Norman Baynard Greensboro, MD</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Ventricular Fibrillation</b> <b>Myocardial Infarction</b> <b>hours</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:10									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10/1/85</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10/1/85</b> , 19 <b>85</b> , to <b>10-1-85</b> , that (I) (we) last saw the deceased alive on <b>7/31</b> , 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Dr. E. Boulais</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>10-2-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-3-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greensboro Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greensboro CA MD</b>			
24. FUNERAL DIRECTOR NAME <b>John E. Boulais</b>				ADDRESS <b>Greensboro, MD</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 8 1985</b>		25b. REGISTRAR'S SIGNATURE <b>John E. Boulais</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and complies with the law, it is to be retained by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

101023

20% COTTON FIBER





301025

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST  
**ELIJAH JEFFERSON BAYNARD**

2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR  
**10 18 85 9:55PM**

3. SEX  
**male**

4. RACE  
**caucasian**

5. DATE OF BIRTH MONTH DAY YEAR  
**10 6 16**

6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS.  
**69** YRS. MONTHS DAYS HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  
**Maryland**

7b. CITIZEN OF WHAT COUNTRY?  
**USA**

8. MARRIED ☒ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH  
**Talbot** MD.

10. CITY OR TOWN OF DEATH  
**Easton**

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)  
**Rt. 3 Box 793, Easton, Md.**

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  
**Bldg. Superint. Bldg. Maintenance**

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  
13a. STATE 13b. COUNTY 13c. CITY OR TOWN  
**Maryland Talbot Easton**

13d. INSIDE CITY LIMITS? YES ☐ NO ☒ 13e. STREET ADDRESS / ZIP CODE  
**Rt. 3 Box 793 / 21601**

14. FATHER'S NAME FIRST MIDDLE LAST  
**John Franklin Baynard**

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST  
**Katie Coleman**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  
**YES NO OR UNKNOWN W W II**

16b. SOCIAL SECURITY NO.  
**218-16-6734**

17. INFORMANT ADDRESS  
**Reeva B. Baynard see 13e.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))  
PART I. DEATH WAS CAUSED BY.  
IMMEDIATE CAUSE (a) **PROSTATE CANCER**  
DUE TO, OR AS A CONSEQUENCE OF (b)  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c)  
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  
**8 YRS**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐  
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR  
**19** 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  
21d. INJURY OCCURRED WHILE ☐ AT WORK NOT WHILE ☐ AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **10-25**, 19 **85**, to **10-18**, 19 **85**, that (I) (we) last saw the deceased alive on **10-12**, 19 **85**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE **Stephen P. Carney, M.D.** DEGREE ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐ 22c. DATE SIGNED  
**10-21-85**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) 22e. ADDRESS  
**Stephen P. Carney, M.D. Dutchman's Lane, Easton, Md.**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE  
**Burial 10-22-85 Spring Hill Easton Talbot Md.**

24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE  
**Newnam Funeral Home, P.A. Easton, Md. OCT 24 1985**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained in 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be immediately filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

BP

60% COTTON FIBER

MADE IN DOMINICA



289103

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Florence C Cannon</b>		2a. DATE OF DEATH MONTH <b>10</b> DAY <b>3</b> YEAR <b>85</b>		2b. HOUR <b>12</b> M.	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>10</b> DAY <b>13</b> YEAR <b>02</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.			
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>		13a. STATE <b>Maryland</b>			
13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Henderson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE <b>Rt. 1 Box 82 A 21640</b>		14. FATHER'S NAME FIRST <b>Clayton</b> MIDDLE <b>Bell</b> LAST <b>Stokley</b>			
15. MOTHER'S MAIDEN NAME FIRST <b>Stella</b> MIDDLE <b>Stokley</b> LAST <b>Stokley</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			
16b. SOCIAL SECURITY NO. <b>213-24-2360</b>		17. INFORMANT ADDRESS <b>Dorothy C. Sculley Henderson, MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic CHF, Angina</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10/1</b> <b>4 yrs</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>no</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>9/15</b> , 19 <b>85</b> , to <b>10/3</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>10/3</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) <b>view the body after death.</b>					
22b. SIGNATURE <b>Wm H Wood</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/3/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm H Wood</b>		22e. ADDRESS <b>EASTON, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-5-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cem.</b>	
23d. LOCATION CITY OR TOWN <b>Sudlersville</b> COUNTY <b>QA</b> STATE <b>MD</b>		24. FUNERAL DIRECTOR NAME <b>John E Boulton's Funeral Home</b> ADDRESS <b>2nd</b>			
25a. DATE RECEIVED BY REGISTRAR <b>10/3/85</b>		25b. REGISTRAR'S SIGNATURE <b>John E Boulton</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the family (fill in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.)

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical history should be handled as above.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 5 8 7

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Charles Raymond Carroll</b>			2a. DATE OF DEATH MONTH <b>10</b> DAY <b>30</b> YEAR <b>85</b>			2b. HOUR <b>3:08</b> M.					
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>May</b> DAY <b>30</b> YEAR <b>1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.					
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chemicals</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Chemical Ind.</b>			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Caroline</b> 13c. CITY OR TOWN <b>Denton</b>											
14. FATHER'S NAME FIRST <b>Charles Edward</b> MIDDLE <b>Carroll</b> LAST <b>Carroll</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Alice</b> MIDDLE <b>Edith</b> LAST <b>Reed</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>218142498</b>				17. INFORMANT ADDRESS <b>Mrs. Alice Bethards, Wilmington, Del.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>probably carcinoma of liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Acute reverse chronic renal failure</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR <b>7</b> A.M. MONTH <b>10</b> DAY <b>30</b> YEAR <b>1985</b> P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <b>Route 3, Box 127</b> CITY OR TOWN <b>Easton</b> COUNTY <b>Maryland</b> STATE <b>MD</b>			21g. DATE SIGNED <b>10/31/85</b>		
22. I certify that (I) (this hospital) attended the deceased from <b>10/30</b> 19 <b>85</b> , to <b>10/30</b> 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>10/30</b> 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) did not view the body after death.)											
22a. SIGNATURE <b>Albert T. Dawkins Jr.</b>				22b. ADDRESS <b>Easton Maryland 21601</b>				22c. DATE SIGNED <b>10/31/85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALBERT T. DAWKINS JR</b>				22e. ADDRESS <b>Route 3, Box 127 Easton Maryland 21601</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>11/4/85</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Denton Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Denton</b> COUNTY <b>Caroline</b> STATE <b>MD</b>		
24. FUNERAL DIRECTOR NAME <b>MOORE FUNERAL HOME</b> ADDRESS <b>DENTON</b>						25a. DATE REC'D. BY REGISTRAR <b>NOV 12 1985</b>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please send page 3 to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Case No. 10000

Date: 10/10/10

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Section: 10000

340016

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST MARY E. CARTER			MONTH DAY YEAR October 30, 1985			11 31 AM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS (LAST BIRTHDAY))			IF UNDER 1 YEAR		
Female	Black	MONTH DAY YEAR 10 01 21	64 YRS			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	U.S.A.		TALBOT MD					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
EASTON	Memorial		Domestic					
13a. USUAL RESIDENCE (IF MARKING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY			13b. CITY OR TOWN			13c. STREET ADDRESS ZIP CODE		
Maryland Queen Anne's			Grasonville			Rt #1 Box 265 21638		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
John F. Hines			Addel Conley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
N/A N/A			24-32-6615			William Carter		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio respiratory arrest.</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <u>Diabetes mellitus, Progressive renal insufficiency</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>10/19</u> 19 <u>85</u> , to <u>10/20</u> 19 <u>85</u> that (I) (we) lost saw the deceased alive on <u>10/20</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE WM H Wood Jr			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/21/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WM H WOOD JR			22e. ADDRESS EASTON, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial			10/24/85		Bryns Com.		Grasonville, GA MD	
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
George Doherty			Easton MD			DEC 4 1985 Julia Thurston-Randall		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and authorized by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 1 (this) should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked at all, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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RECEIVED

NOV 11 1964

DEC 4 1964



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 5 8 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Joseph WILLIAM Collins			2a. DATE OF DEATH MONTH DAY YEAR 10 2 85		2b. HOUR 7:15 PM
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Feb. 9, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County MD	
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Constr. Wkr.		12b. KIND OF BUSINESS OR INDUSTRY Construction
13a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 3a. STATE Maryland			13b. COUNTY Caroline	13c. CITY OR TOWN Denton	
14. FATHER'S NAME FIRST MIDDLE LAST Harvey Marvel Collins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Riley Mae Elliott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215030106		17. INFORMANT ADDRESS Mrs. Nan N. Collins, Denton, MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Acute Renal Failure DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema + Respiratory Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 wks 3 wks years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: GI Bleeding					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/17/85 to 10/2/85, the (I) (we) last saw the deceased alive on 10/2/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did not) view the body after death.					
22b. SIGNATURE William J. Banfield MD				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William J. Banfield, M.D.				22e. ADDRESS 505 Dutchmens Lane, Easton, MD 21601	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/4/85		23c. NAME OF CEMETERY OR CREMATORY Denton Cemetery	
23d. LOCATION CITY OR TOWN Denton		23e. COUNTY Caroline		23f. STATE MD	
24. FUNERAL DIRECTOR NAME M/O 11/13 FUNERAL HOME DENTON MD				25a. DATE REC'D. BY REGISTRAR 9 1985	
25b. REGISTRAR'S SIGNATURE Julia Davidson					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.





10/10/52

2020 03 2020

NAME: [illegible]  
RESIDENCE: [illegible]  
BIRTH: [illegible]

EDUCATION: [illegible]  
OCCUPATION: [illegible]

RELIGION: [illegible]  
MARRIAGE: [illegible]

CHILDREN: [illegible]

NOTES: [illegible]

REFERENCE: [illegible]

ADDITIONAL INFORMATION: [illegible]

DATE OF BIRTH: [illegible]

DATE OF DEATH: [illegible]

308007

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 5 2 9 5 8 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Arthur Coulbourne</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-23-85</b>		2b. HOUR MIN. <b>4:37</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 26 04</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>81</b>	IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>--</b>	7b. CITIZEN OF WHAT COUNTRY? <b>--</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.	
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Handyman</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>
13a. STATE <b>Md.</b>		13b. COUNTY <b>Dorchester</b>	13c. CITY OR TOWN <b>Cambridge</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE <b>Box 182 21613</b>
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Unkn.</b>		16b. SOCIAL SECURITY NO. <b>218-14-4030</b>		17. INFORMANT ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Bilateral lower lobe pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Recent brain stem stroke (Asteroid) - Carcinoma of Cecum</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Recent brain stem stroke (Asteroid) - Carcinoma of Cecum</b>					
19a. DATE OF OPERATION <b>10/7/85</b>	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Bowel obstruction</b>	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/22/85</b> to <b>10/23/85</b> , that (I) (we) last saw the deceased alive on <b>10/22/85</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Robert T. Dawkins M.D.</b>		DEGREE	22c. DATE SIGNED <b>10/23/85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert T. Dawkins Jr.</b>		22e. ADDRESS <b>Route 3 Box 127 Easton, Maryland 21601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>	23b. DATE <b>10/25/85</b>	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Anatomy Board</b>		ADDRESS <b>Balto., Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>NOV 1 1985</b>	25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Medical Examiner's Office

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 5 9 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN H. CROCKER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 14 85</b>		2b. HOUR <b>12:05AM</b>
3 SEX <b>female</b>	4 RACE <b>caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 3 1898</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.	
7a. BIRTHPLACE COUNTRY <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.	
10 CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Talbot House, Mecklenberg Ave.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Easton</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST <b>Clarence Kell</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes O'Neill</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>217-48-8579</b>		17 INFORMANT ADDRESS <b>Rt. 3 Box 312 Easton, Md. 21601</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>FACTOR ARTERY THROMBOSIS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>AS I D</b>					<b>15 YRS</b>
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>6 Oct 1985</b> to <b>14 Oct 1985</b> , that (I) (we) last saw the deceased alive on <b>17 Sep 1985</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Stephen P. Carney</i>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/15/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen P. Carney, M.D.</b>		22e. ADDRESS <b>Dutchman's Lane, Easton, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-16-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot Md.</b>
24 FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>			ADDRESS <b>Easton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 17 1985</b>
					25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>

MEDICAL CERTIFICATION

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20% COTTON FIBER

WINDFALL



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1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 5 29591

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
Albert Thompson Dawkins Sr.					10	18	85		10 <sup>30</sup> P.M.
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
male	caucasian	MONTH DAY YEAR 7 30 14		71	MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA			Talbot County MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Easton	Easton Memorial			Merchant		Store Owner			
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE				
Maryland		Talbot	Easton		Rt. 3 Box 464/21601				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Edward R. Dawkins		FIRST MIDDLE LAST Lillie Mae Leaverton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
NO		217-03-5115		Shirley A. Dawkins see 13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ENCEPHALITIS DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8/13/85
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a PNEUMONIA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE
22a. I certify that (I) (this hospital) attended the deceased from 8/13/85, 19_____, to 8/18/85, 19_____, that (I) (we) last saw the deceased alive on 10/18/85, 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
C. R. W. BARN		MD				10/19/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
C. R. W. BARN		Easton, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY	STATE	
Burial		10-22-85	Spring Hill		Easton		Talbot	MD.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Newnam Funeral Home		Easton, Md. 21601		OCT 24 1985					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 5 9 2

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>MILDRED M. DENNY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 3 85</b>		2b. HOUR <b>12:30</b> M
3. SEX <b>female</b>	4. RACE <b>caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>9 31</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.	
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Rt. 3, Stoney Ridge, Easton</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>School Teacher</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Easton</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Lee Ceril Morrissey</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mildred Ruth Davis</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>208-24-0078</b>		17. INFORMANT <b>W. Lee Denny</b> ADDRESS <b>P.O. Box 1893 Easton, Md. 21601</b>	
18. CAUSE OF DEATH: Enter only one cause per line (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic Alcoholism</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot Md.</b>	
22. I certify that (1) (the hospital) attended the deceased from <b>19 55</b> to <b>3 Oct 19 55</b> , that (1) (was) lost saw the deceased die on <b>3 Oct 19 55</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (If (you) (we) saw the body after death, state date and hour.)					
22a. SIGNATURE <b>R. Lane Wroth, M.D.</b> DEGREE <b>M.D.</b>				22c. DATE SIGNED <b>10-4-85</b>	
22b. ADDRESS <b>St. Michaels, Md. 21663</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>10-7-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>		ADDRESS <b>Easton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 9 1985</b>	25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

28-032

2025 COLLECTION



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>George OBER Dulin JR.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-19-85</b>			2b. HOUR <b>2:20 PM</b>				
3. SEX <b>male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 1 28</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 2 YRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD				
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>none</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Easton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>903 S. Washington St./21601</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>George O. Dulin Sr.</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie Mae Jones</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>217-80-4442</b>		17. INFORMANT ADDRESS <b>Mary A. Mushaw see 13e.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>respiratory failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>carcinoma ampulla of Vater</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>liver failure</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>10-14</b> , 19 <b>85</b> , to <b>10-19</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>10-19</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <b>[Signature]</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>10-19-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. Sanchez</b>			22e. ADDRESS <b>22 Commerce St Easton</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10-21-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>					ADDRESS <b>Easton, Md. 21601</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 24 1985</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician a burial or cremation permit will be issued in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

10-14-82  
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Teddy

My dear Mr. [unclear]

RECEIVED  
NATIONAL ARCHIVES  
10-14-82



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1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 5

2 9 5 9 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST GLADYS ELIZABETH ELLIOTT			MONTH DAY YEAR 10 - 7 - 85			12 <sup>05</sup> PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
female	caucasian	MONTH DAY YEAR 3 11 06	79 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland	USA		TALBOT MD.					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
EASTON	WILLIAM HILL MANOR			Reg. Nurse			Nursing	
13a. STATE			13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS / ZIP CODE			
Maryland			Talbot	Easton	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	501 Dutchman's Lane / 21601		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Marion C. Williams			FIRST MIDDLE LAST Emma Elizabeth Calloway					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS		
NO			271-42-2848			Julius R. Elliott see 13e.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE Cause (a) ASCVD								years
DUE TO, OR AS A CONSEQUENCE OF								
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a								
Peptic Ulcer Disease; Chronic Brain Syndrome								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from JUNE 9 19 84 to 10/7 19 85, that (I) (we) last saw the deceased on 10/11 19 85, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
William Banfield			MD					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
William Banfield, M.D.			Dutchman's Lane, Easton, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION	
Burial			10-10-85	Spring Hill			Easton Talbot Md.	
24. FUNERAL DIRECTOR NAME						25a. DATE REC'D. BY REGISTRAR		
Newnam Funeral Home Easton, Md.						OCT 14 1985		
						25b. REGISTRAR'S SIGNATURE		
						John Davidson-Randall		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

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ANALYSIS OF THE SAMPLES



301041

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS OF DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE REGISTRATION NO. 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH REGISTRATION NO. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

07/84  
25MBP  
DHMH - 17  
(VR A15 ME (5))1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

29595

1 DECEASED NAME (TYPE OR PRINT) <b>Robert Burton Ewing</b>			2a DATE KNOWN OF DEATH ESTIMATED <b>10 21 1985</b>			2b HOUR <b>8:30 AM</b>		
3 SEX <b>male</b>	4 RACE <b>caucasian</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>8 31 22</b>	6 AGE (IN YEARS) (LAST BIRTHDAY) <b>63 YRS.</b>	7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot MD</b>	
10 CITY OR TOWN OF DEATH <b>Easton</b>			11 NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital at Easton</b>			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>electrician</b>		
13a STATE <b>Maryland</b>			13b CITY <b>Talbot</b>			13c CITY OR TOWN <b>Easton</b>		
14 FATHER'S NAME FIRST MIDDLE LAST <b>Milton G. Ewing, Sr.</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy Anna Dulin</b>			16a USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16b SOCIAL SECURITY NO. <b>215-26-5749</b>		
17a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>			17b IF YES, GIVE WAR OR DATES <b>WW II</b>			17c INFORMANT <b>James L. Ewing</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic Coronary Artery Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 1a:								
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <b>R. Lane Wroth</b>			M.D. <b>Deputy</b>			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) <b>R. Lane Wroth, M.D.</b>			ADDRESS <b>St. Michaels, Md.</b>					
23a BURIAL, CREMATION, REMOVAL SPECIFY <b>Burial</b>			23b DATE <b>10-23-85</b>			23c NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>		
24 FUNERAL DIRECTOR NAME ADDRESS <b>Newnam Funeral Home Easton, Md.</b>			23d LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot Md.</b>			25a DATE REC'D. BY REGISTRAR <b>OCT 24 1985</b>		
			25b REGISTRAR'S SIGNATURE <b>Davidson</b>					



140108



UNITED STATES

NAVY

RECEIVED

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RECEIVED

140108

301042

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 5 9 6

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>EVA ESTELLE FAULKNER</b>			2a DATE OF DEATH MONTH <b>10</b> DAY <b>18</b> YEAR <b>85</b>		2b. HOUR <b>M</b>
3 SEX <b>female</b>	4 RACE <b>caucasian</b>	5. DATE OF BIRTH MONTH <b>11</b> DAY <b>9</b> YEAR <b>01</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b>	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.	
10 CITY OR TOWN OF DEATH <b>Tilghman</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Wharf Road, Tilghman, Md.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b> 13b COUNTY <b>Talbot</b> 13c CITY OR TOWN <b>Tilghman</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>Wharf Road/ 21671</b>	
14 FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>Henry</b> LAST <b>Tilghman</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Alice</b> MIDDLE <b>Vincent</b> LAST <b>Vincent</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>220-32-0557</b>		17 INFORMANT <b>Box 57 Doris Faulkner Tilghman, Md. 21671</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MALIGNANT LYMPHOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>21 mo</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>2-21</b> , 19 <b>84</b> , to <b>10-18</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>8-25</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stephen P. Carney</b>		DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/18/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen P. Carney, M.D.</b>		22e. ADDRESS <b>Dutchman's Lane, Easton, Md. 21601</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-21-85</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Tilghman Un.Meth.Cemetery Tilghman Talbot Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE
24 FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>		ADDRESS <b>Easton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 24 1985</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

FOX COTTON FIBER

WHITE WAM BROWN



290085

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 5 9 7

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Joseph</b>			2a. DATE OF DEATH MONTH <b>October</b> DAY <b>10</b> YEAR <b>1985</b>			2b. HOUR <b>120</b> M					
3. SEX <b>male</b>		4. RACE <b>caucasian</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>31</b> YEAR <b>1893</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>92</b>		6. IF UNDER 1 YEAR MONTHS <b>YRS.</b> DAYS <b>HRS.</b> MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.					
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Attorney</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Law</b>			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Easton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Dutchman's Lane/21601</b>		
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>C.</b> LAST <b>France</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Roberta</b> MIDDLE <b>Simon</b> LAST <b>Simon</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>			16b. SOCIAL SECURITY NO. <b>WWI</b>		17. INFORMANT <b>P.O. Box 987</b>		ADDRESS <b>Easton, Md. 21601</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive heart failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Uncertain</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>&lt; 6 mos.</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Acute lower GI bleeding, cause not determined</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>10-4</b> , 19 <b>85</b> , to <b>10-10</b> , 19 <b>85</b> , that (1) (we) last saw the deceased alive on <b>10-10</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Robert W. Trever, M.D.</b>					DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>10-10-85</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Robert W. Trever, M.D.</b>					22e. ADDRESS <b>RD 3 Box 297 Easton, Md. 21601</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>			23b. DATE <b>10-11-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salisbury Crematory</b>			23d. LOCATION CITY OR TOWN <b>Salisbury</b> COUNTY <b>Wic.</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>					ADDRESS <b>Easton, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>OCT 15 1985</b>			
					25b. REGISTRAR'S SIGNATURE <b>Julia Swisher-Rendall</b>						

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

Joseph Francis

1847

St. Charles



289172

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR <u>Geneva S. Gambrill</u>									
1. DECEASED NAME (Type in Print) <u>Geneva S. Gambrill</u>					2a. DATE OF DEATH MONTH <u>10</u> DAY <u>8</u> YEAR <u>85</u>		2b. HOUR <u>4:05</u> PM		
3. SEX <u>female</u>		4. RACE <u>caucasian</u>		5. DATE OF BIRTH MONTH <u>12</u> DAY <u>21</u> YEAR <u>15</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>69</u> YRS		IF UNDER 1 YEAR MONTHS <u>1</u> DAYS <u>1</u> IF UNDER 24 HRS. HOUR <u>1</u> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Pennsylvania</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Talbot</u> MD.			
10. CITY OR TOWN OF DEATH <u>Easton</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Memorial</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <u>Maryland</u>		13b. COUNTY <u>Talbot</u>		13c. CITY OR TOWN <u>Oxford</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <u>501 Willows Ave./21654</u>	
14. FATHER'S NAME FIRST <u>Joseph</u> MIDDLE <u>M.</u> LAST <u>Stull, Sr.</u>					15. MOTHER'S MAIDEN NAME FIRST <u>Matilda</u> MIDDLE <u>Y.</u> LAST <u>Gaul</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>194-32-3975</u>		17. INFORMANT ADDRESS <u>10 Spring St. Media, Pa. 19063</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute Myocardial Infarct</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic &amp; Hypertensive Ht Dis.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Years</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR <u>A.M.</u> MONTH <u>19</u> DAY <u>19</u> YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>David A. Stout, M.D.</u>				DEGREE <u>MD</u>				22c. DATE SIGNED <u>10/9/85</u>	
22d. PHYSICIAN'S NAME (TYPE IN PRINT) <u>David A. Stout, M.D.</u>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>10-12-85</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hill Crest</u>		23d. LOCATION CITY OR TOWN <u>Federalburg</u> COUNTY <u>Caro</u> STATE <u>Md.</u>			
24. FUNERAL DIRECTOR NAME <u>Newnam Funeral Home</u> ADDRESS <u>Easton, Md</u>				25a. DATE REC'D. BY REGISTRAR <u>OCT 14 1985</u> 25b. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>					

BP



RECEIVED

Target

Carbon Monoxide

Heart Failure  
Acute Myocardial Infarction  
Hypertension

4/11/10

10/1/10



294045

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5

REG. NO.

2 9 5 9 9

1. DECEASED NAME (TYPE OR PRINT) <b>MARY EEDITH GANNON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>10-11-85</b>		2b. HOUR <b>717 P.M.</b>	
3. SEX <b>female</b>		4. RACE <b>caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 12 04</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS	
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NO IN-SUCH FACILITY, GIVE STREET ADDRESS) <b>MEMORIAL HOSPITAL</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE <b>Maryland</b>		12b. CITY OR TOWN <b>Greensboro</b>		12c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13a. FATHER'S NAME FIRST MIDDLE LAST <b>Edward J. Hopkins</b>		13b. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary M. Christian</b>		17. INFORMANT <b>RT. 1 Box 428</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>220-01-8133</b>		17. INFORMANT <b>Mary K. Allen</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEPATIC FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>UNCERTAIN</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 DAYS</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/11/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAROLD E. ISAUER M.D.</b>		22e. ADDRESS <b>MEM HOSP EASTON MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-15-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill</b>	
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>		ADDRESS <b>Easton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 17 1985</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be returned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.



HEROLD F. JAMES  
QUESTIONS

X

X

X

NO. 10

HEROLD F. JAMES, JR.  
1011 1/2 E. 10th St., W.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 6 0 0

1- FOR  
STATE  
REGISTRAR

Mildred M. Gootee

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>Mildred M. Gootee</b>			2a DATE OF DEATH MONTH DAY YEAR <b>10-19-85</b>			2b HOUR <b>9p's</b>			
3 SEX <b>female</b>		4 RACE <b>white</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Aug 26 1903</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b>			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.			
10 CITY OR TOWN OF DEATH <b>Easton</b>		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Alseemorial</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b>		13b COUNTY <b>Dor.</b>		13c CITY OR TOWN <b>Church Creek</b>		13d INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e STREET ADDRESS / ZIP CODE <b>State Rt. 336 21622</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Harry Wallace</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Wilson</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b SOCIAL SECURITY NO. <b>218-12-9336</b>		17 INFORMANT ADDRESS <b>Star Rt. Box 19</b> <b>D Mildred Shorter Church Creek Md.</b>					

18 CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.  
PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a)

**Congestive Heart Failure**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**Hours**

DUE TO, OR AS A CONSEQUENCE OF

(b) **ASCVD**Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

**CATATONIC SCHIZOPHRENIA**

19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (his hospital) attended the deceased from <b>10/19</b> 19 <b>85</b> to <b>10/19</b> 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated							
22b SIGNATURE <b>William J. Banfield</b>				DEGREE <b>MD</b>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (IF OTHER THAN 22b)				22e ADDRESS		22f MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>	
<b>William J. Banfield, Md.</b>				<b>Easton, Md. 21601</b>			

23a BURIAL, CREMATION, REMOVAL 13a <b>burial</b>		23b DATE <b>10/22/85</b>		23c NAME OF CEMETERY OR CREMATORY <b>Dor. Mem. Park</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Cambridge Dor. Md.</b>	
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24 FUNERAL DIRECTOR NAME <b>John T. Jones 700 South St - Cambridge, Md.</b>		25a DATE REC'D. BY REGISTRAR <b>24 12 9 1985</b>		25b REGISTRAR'S SIGNATURE <b>John T. Jones</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic cause, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

Q



CATHOLIC SCHOLARSHIP

William J. ...

...

...

...

296152

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

85

29601

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William F Frank Harvest</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>10-15-85</b>		2b. HOUR MIN. <b>11:05 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9-4-1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>85</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.	
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital at Easton</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Minister</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Md. Caroline Preston</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Harvest</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennie Harvest</b>		16. SOCIAL SECURITY NO. <b>197-03-8304</b>			
17. INFORMANT (Spouse) ADDRESS <b>Preston Md.</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>ASCVD with Broken Stem</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>10-14-85</b> <b>10-15</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Coronary artery Dis &amp; hypertension; Hypertension</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10-14</b> , 19 <b>85</b> to <b>10-15</b> , 19 <b>85</b> , that (I) (we) lost saw the deceased alive on <b>10-15</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Terry P. Detrich</b>				DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c. DATE SIGNED <b>10-15-85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Terry P. Detrich</b>				22e. ADDRESS <b>140 S. Washington St. Easton, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-20-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beckwith Neck</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Beckwithneck Dor. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>L.H. BORDERER</b>				ADDRESS <b>CARLE, MD.</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





294117

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

B 5 2 9 6 0 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James A. Hassett			2a. DATE OF DEATH MONTH DAY YEAR 10-2-85			2b. HOUR 8:29 AM			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 25, 1899		6 AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Nr. Federalburg, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.			
10 CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital at Easton				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic - Owner		12b. KIND OF BUSINESS OR INDUSTRY of Garage	
13a. STATE Maryland		13b. COUNTY Caroline		13c. CITY OR TOWN Federalburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 221 Liberty Road 21632	
14 FATHER'S NAME FIRST MIDDLE LAST William G. Hassett			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Coulbourn			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 217-30-7562A			17 INFORMANT ADDRESS Federalburg, Md. Mrs. Helen R. Hassett, 221 Liberty Road,						

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY

## IMMEDIATE CAUSE (a)

Cardiopulmonary failure

## DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost

(b) Infection

## DUE TO, OR AS A CONSEQUENCE OF

(c) Dehydration

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

## PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Gary Sprouse, M.D.				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Gary Sprouse, M.D.				Easton, MD 21601			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 5, 1985		23c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Federalburg, Caroline, Maryland	
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24 FUNERAL DIRECTOR NAME Frankton - Aoulains Bay 45 Federalburg, Md 21632		25a. DATE REC'D. BY REGISTRAR OCT 14 1985		25b. REGISTRAR'S SIGNATURE John E. Brown	
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DHMM - 16 60M 7/B4

(VRA 15, 4)

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital's attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove all stamps. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or funeral. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other trauma, the medical examiner must be notified.



1000

Cardiomyopathy failure

Infection

Dehydration

Easton, MD 21601

Gary Shouse, M.D.





*[Faint, illegible handwritten text covering the majority of the page, likely bleed-through from the reverse side.]*

301043

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 6 0 4

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) ALBERT LESLIE HENDERSON			2a. DATE OF DEATH MONTH DAY YEAR 10 21 85		2b. HOUR 12:30PM
3 SEX male	4 RACE caucasian	5. DATE OF BIRTH MONTH DAY YEAR 3 1 08		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas	7b. CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10. CITY OR TOWN OF DEATH Easton	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 202 E.Dover St., Easton		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Civil Engineer		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Talbot	13c. CITY OR TOWN Easton	
14. FATHER'S NAME FIRST MIDDLE LAST Frank L. Henderson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Lovett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 248-09-6430		17. INFORMANT Rt. 1 Box 122A Lynne H. Rich Oxford, Md. 21654	

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

4-6 HRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Diffuse atherosclerotic cardio vascular disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost _____, the deceased alive on _____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Lawrence D. Bohan, M.D.				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
Lawrence D. Bohan, M.D.				Dutchman's Lane, Easton, Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) cremation	23b. DATE 10-22-85	23c. NAME OF CEMETERY OR CREMATORY Salisbury Crematory	23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wic. Md.
24. FUNERAL DIRECTOR NAME Newnam Funeral Home		ADDRESS Easton, Md.	25a. DATE REC'D. BY REGISTRAR OCT 24 1985
		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

8

CHIEF

SECTION



1943-44

To the Honorable Member of the Council

James P. [unclear]  
X

BP

DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the death certificate from the file. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be made.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
1 - FOR REGISTRAR										
REG. NO. 85 29605										
1 DECEASED NAME (TYPE OR PRINT) <b>John H. Howard</b>						2a DATE OF DEATH MONTH DAY YEAR <b>10-18-85</b>		2b HOUR MIN. <b>11:25 A</b>		
3 SEX <b>Male</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>01 12 69</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS <b>76</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.				
10 CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital at Easton</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY		
13a STATE <b>Maryland</b>			13b COUNTY <b>Talbot</b>		13c CITY OR TOWN <b>Easton</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>Hanson Street 21401</b>	
14 FATHER'S NAME <b>Albert</b>			MIDDLE <b>Howard</b>		LAST <b>Howard</b>		15. MOTHER'S MAIDEN NAME <b>Lizzie Chase</b>		FIRST <b>Lizzie</b> MIDDLE <b>Chase</b> LAST	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>			16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>N/A</b>		17 INFORMANT <b>Lona Brooks</b>		ADDRESS			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>Hypertensive cardiovascular disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>Uncertain</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>None</b>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from <b>3-25</b> , 19 <b>75</b> , to <b>10-18</b> , 19 <b>85</b> , that (1) (we) last saw the deceased alive on <b>10-18</b> , 19 <b>85</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) did not view the body after death.										
22b SIGNATURE <b>Robert W. Trever, M.D.</b>						DEGREE <b>ATTENDING PHYSICIAN</b> <input checked="" type="checkbox"/> <b>MEDICAL DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input type="checkbox"/>		22c DATE SIGNED <b>10-18-85</b>		
22d PHYSICIAN'S NAME (TYPE OR PRINT)					22e ADDRESS <b>RD 3 Box 297 Easton, Md. 21601</b>					
23a BURIAL, CREMATION, REPOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>10/24/85</b>		23c NAME OF CEMETERY OR CREMATORY <b>Richardson</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot MD</b>			
24 FUNERAL DIRECTOR <b>Lisa H. Wasell, Etc.</b>					25 DATE REC'D. BY REGISTRAR <b>OCT 22 1985</b>		25b REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

12

Received of the Treasurer of the  
Board of Directors of the  
City of New York

the sum of \$100.00  
for the purchase of  
the City of New York

for the purchase of  
the City of New York

for the purchase of  
the City of New York

for the purchase of  
the City of New York



288130

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Clifton A Hubbard</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 6 1985</b>			2b. HOUR MIN. <b>1:31 PM</b>				
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02 17 06</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>79</b>		6. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.				
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Night Watchman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Labore</b>		
13a. STATE <b>MD</b>			13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Preston</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt 1, Box 57 21655</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALEXANDER Hubbard</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARTHA Sharp</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>189-16-7447</b>		17. INFORMANT <b>Cleo Hubbard</b>		18. ADDRESS <b>SAME</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary atherosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (is this hospital) attended the deceased from <b>Sept 10/12 1980</b> to <b>10/6 1985</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) (see) the body after death.										
22b. SIGNATURE <b>William J. Banfield</b>						DEGREE <b>MD</b>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William J. Banfield, M.D.</b>						22e. ADDRESS <b>Easton, Md. 21601</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>10/12/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Pleasant</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Preston Car. MD.</b>			
24. FUNERAL DIRECTOR NAME <b>Eric Washburn</b>						ADDRESS <b>P.O. Box 606 Easton, MD.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 10 1985</b>		
						25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be detached for use as the burial-transit permit. Then please remove carbon papers and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, it should be marked as such.

528130



NOVA MILITARIA  
FOR COLONIALS

NOV 10 1961

290084

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 6 0 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Alice DANIEL Huxley</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-10-85</b>		2b. HOUR <b>12:50 P.M.</b>								
3 SEX <b>F</b>		4 RACE <b>W</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8 18 10</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>75</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8 IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN) <b>Alabama U.S.A.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot Co.</b> MD.							
10. CITY OR TOWN OF DEATH <b>Easton, Md</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital Easton, Md</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <b>Maryland</b>						13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Easton</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>Rt. 4 Baileys Neck/21601</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert T. Daniel</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emogene Thomas</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>040-38-4673</b>		17. INFORMANT ADDRESS <b>William P. Huxley see 13e.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma of Breast</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>July</b> , 19 <b>72</b> , to <b>October 10</b> , 19 <b>85</b> , that (I) (we) last saw the deceased alive on <b>10/10</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>Wm H Wood</b>								DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm H Wood</b>								22e. ADDRESS <b>Easton, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>				23b. DATE <b>10-11-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salisbury Crematory</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wic. Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>								ADDRESS <b>Easton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 15 1985</b>		25b. REGISTRAR'S SIGNATURE <b>J. H. Anderson</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 6 0 8

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <b>HARRY W. KIRBY</b>		2a DATE OF DEATH MONTH DAY YEAR <b>10 - 19 - 85</b>		2b HOUR <b>6p</b> M	
3 SEX <b>Male</b>	4 RACE <b>Cauc.</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Aug. 23. 1901</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.		
10 CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Recreational</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>B&amp;O Railroad</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Car. Service</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Maryland</b>		13b COUNTY <b>Talbot</b>	13c CITY OR TOWN <b>Easton</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>James Esbury Kirby</b>		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Buckner</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>705-03-8002</b>	17 INFORMANT ADDRESS <b>Harold W. Miller 431 N. Bouldin St. Baltimore, Md. 21224</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA PROSTATE</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>July 1985.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <b>7/1/85</b> 19 to <b>10/19/85</b> 19, that (I) (we) last saw the deceased alive on <b>10/11/85</b> 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>C. R. W. Bain</b>		DEGREE <b>M.D.</b>		22c DATE SIGNED <b>10/20/85.</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. R. W. Bain</b>		22e ADDRESS <b>Easton, Md. 21601</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b DATE <b>Oct. 21, 1985</b>	23c NAME OF CEMETERY OR CREMATORY <b>Olivet Cemetery</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>St. Michaels, Talbot Md.</b>		

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

H

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. These permits are required by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 indicates injury, or other traumatic cause, the medical examiner must be notified to come.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

24 FUNERAL DIRECTOR  
NAME  
**James E. Leonard**

25 DATE REC'D. BY REGISTRAR  
**OCT 25 1985**

26 REGISTRAR'S SIGNATURE  
**John T. ...**

802003

FORWARD

Aug. 23, 1901

Genl.

Maile

U.S.A.

Married

1800 Married Genl. Service

1800 Married Genl. Service

Married 1800 Genl. Service

James Barker

James Barker

702-03-8003 Harold V. Miller Baltimore, Md. 21214

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No



Genl. 23, 1901 Olive Cemetery St. Michael, Talbot Co.



303055

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Martha E. Leaming</b>			2a DATE OF DEATH MONTH DAY YEAR <b>10-24 85</b>			2b HOUR <b>6<sup>20</sup> AM</b>			
3 SEX <b>female</b>		4 RACE <b>caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>10 7 01</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>unknown</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.			
10 CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN A FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE <b>Maryland</b>		13b COUNTY <b>Talbot</b>		13c CITY OR TOWN <b>Easton</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <b>531 Trippe Ave./21601</b>	

14 FATHER'S NAME FIRST MIDDLE LAST <b>Arthur Jauird McCann</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maude Belle English</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) <b>092-03-0302</b>		17 INFORMANT <b>P.O. BOX 1209, Easton Md. Ernest M. Thompson, Per. Rep.</b>	

18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (b) <b>REFRACTORY CHRONIC HEART FAILURE</b> <b>4 YRS.</b>	
		DUE TO, OR AS A CONSEQUENCE OF (c) <b>CARDIOMYOPATHY</b> <b>4 YRS.</b>	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>9/23 19 85</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>403 MARVEL CT. EASTON, MD.</b>			
22a. I certify that (a) (this hospital) attended the deceased from <b>10/24 19 85</b> to <b>10/24 19 85</b> , that (b) (we) last saw the deceased on <b>10/24 19 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If the signer did not view the body after death, so state.)							
22b. SIGNATURE <b>Scott D. Friedman</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>10/24/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SCOTT D. FRIEDMAN</b>				22e. ADDRESS <b>403 MARVEL CT. EASTON, MD.</b>			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>		23b. DATE <b>10-25-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Delmarva Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lewes Sussex Del.</b>	
24 FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>				ADDRESS <b>Easton, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 28 1985</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and return page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the death certificate must be filed with the State Dept. of Health and Mental Hygiene.

BP



11/11/11

T.H.T.

11/11/11

11/11/11

11/11/11

DIVISION OF VITAL RECORDS, 301 N. PRINCE ST., BALTIMORE, MD. 21201

**TO MEDICAL EXAMINER:** THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 72 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE  
PENCIL IN THE WORD "PENDING".  
**PAGE 1** OF TWO PAGES. PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.  
**PAGE 4** SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES.  
**TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS  
AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION ON THE RECORDS. 301 W. PRESTON STREET,  
BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (5))  
15M 7/76

STATE OF MARYLAND										29610	
DEPARTMENT OF HEALTH AND MENTAL HYGIENE										5	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES ALDRIDGE LEDNUM</b>										2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH DAY YEAR <b>10 28 85</b>	
3. SEX 4. RACE 5. DATE OF BIRTH MONTH DAY YEAR 6. AGE (IN YEARS) LAST BIRTHDAY YRS. 7. CITIZEN OF WHAT COUNTRY? 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>male caucasian 3 29 16 69 YRS. USA Talbot</b>										2b. HOUR <b>M</b>	
10. CITY OR TOWN OF DEATH 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY <b>Tilghman Coopertown Road, Tilghman Retired Waterman Waterman</b>											
13a. STATE 13b. COUNTY 13c. CITY OR TOWN 13d. INSIDE (CITY LIMITS?) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>Maryland Talbot Tilghman Coopertown Road, Tilghman</b>											
14. FATHER'S NAME FIRST MIDDLE LAST 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ira Lednum, Sr. Esta Mae Frampton</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. 17. INFORMANT ADDRESS <b>NO 218-20-8117A Ira C. Lednum 714 Elizabeth St. Easton, Md.</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>C.V.D.</b> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0</b>	
19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. — 19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Found dead in home</b>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion</b>											
ACTUAL SIGNATURE <b>Louis S. Welty</b> TITLE (SPECIFY) <b>for Sep</b> MEDICAL EXAMINER DATE SIGNED <b>10-29-85</b> <b>Louis S. WELTY</b> ADDRESS <b>EASTON, Md</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 23b. DATE 23c. NAME OF CEMETERY OR CREMATORY 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Burial 11-1-85 Tilghman Methodist Tilghman Talbot Md.</b>											
24. FUNERAL DIRECTOR NAME ADDRESS 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>Newnam Funeral Home Easton, Md. OCT 31 1985 [Signature]</b>											



295016

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 6 1 1

FOR  
1 - STATE REGISTRAR Delcie M. Iednum

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <i>Delcie M. Iednum</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10 - 5 - 85</i>			2b. HOUR <i>5</i> MIN <i>35</i>				
3 SEX <i>Female</i>		4 RACE <i>Cauc.</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>Aug, 29, 1909</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>76 (5)</i> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD				
10 CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Murdoch Garden</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Florist</i>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <i>Maryland</i>			13b COUNTY <i>Talbot</i>		13c CITY OR TOWN <i>St. Michaels</i>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <i>1.07 Seymour Ave. 21663</i>	
14 FATHER'S NAME FIRST MIDDLE LAST <i>Samuel Otto Fairbank</i>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Nettie Burrows</i>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>217-07-0888</i>		17 INFORMANT ADDRESS <i>Patricia L. Evans 109 E. Maple St. St. Michaels, Md. 21663</i>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Metastatic Cancer of Breast</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>9/19 1985</i>			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from <i>9/19 1985</i> , to <i>10/7 1985</i> , that (I) (we) last saw the deceased alive on <i>10/7 1985</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE <i>Wm H Wood</i>						DEGREE <i>MD</i>		22c. DATE SIGNED <i>10/7/85</i>		
22d PHYSICIAN'S NAME (TYPE OR PRINT) <i>William H. Wood, M.D.</i>						22e ADDRESS <i>E-Easton, Md 21601</i>				
23a BURIAL, CREMATION, REMOVAL (CHECK #) <i>Burial</i>			23b DATE <i>Oct. 8, 1985</i>		23c NAME OF CEMETERY OR CREMATORY <i>Woodlawn Mem. Park</i>		23d LOCATION CITY OR TOWN COUNTY STATE <i>Easton Talbot Maryland</i>			
24 FUNERAL DIRECTOR NAME <i>Samuel E. Leonard</i>						25a DATE REC'D. BY REGISTRAR <i>OCT 14 1985</i>		25b REGISTRAR'S SIGNATURE <i>John D. ...</i>		

MEDICAL CERTIFICATION

BP  
DHMH - 16 60M 7/B4  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and positively filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 contains any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

NEW PATIENT

DATE

AUG. 29, 1909

70

MARYLAND

1.2.1.

Outdoor Gastrologist

MARYLAND Talbot St. Michael's X

107 Seymour Ave. 21007

Samuel Otto Ventrone

Hattie Horvath

No

-----

217-07-0000 Patricia A. Evans

109 E. Maple St.  
St. Michaels, Md.

21003

Metastatic Cancer of Breast

William H. Wood, M.D.

Easton, Md. 21001

Oct. 5, 1905 Woodlawn Mem. Park Easton Talbot Maryland

298100

FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

5 2 9 6 1 2

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Edward Franklin Lewis</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10-17-85</b>			2b. HOUR MIN. <b>7:43 A</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 21, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.	
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital at Easton</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer and Ferryboat Purser</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Queen Anne</b>		13c. CITY OR TOWN <b>Chester</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Lewis</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Gespert</b>		16. SOCIAL SECURITY NO. <b>215-20-4347</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-20-4347</b>		17. INFORMANT ADDRESS <b>Betty V. Hoxter, Rt. 1 Box 436, Chester, MD 21619</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9/12/85</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>RENAL INSUFFICIENCY</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/12/85</b> , 19____, to <b>10/17/85</b> , 19____, that (I) (we) lost saw the deceased alive on <b>10/14/85</b> , 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.							
22b. SIGNATURE <b>C.R.W. Bain</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/17/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C.R.W. Bain</b>		22e. ADDRESS <b>Easton, Md. 21601</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10-19-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Stevensville Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Stevensville Q.A. MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Tom Helfenbein Funeral Home, Chester, MD 21619</b>				25a. DATE REC'D. BY REGISTRAR <b>OCT 23 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Jane W. Anderson</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 14 days after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, added in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and an autopsy performed.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 6 1 3

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Redmond Otto Long</b>			2a. DATE OF DEATH MONTH <b>10-</b> DAY <b>9-</b> YEAR <b>85</b>			2b. HOUR <b>30</b> MIN. <b>12 PM</b>			
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>Sept.</b> DAY <b>2,</b> YEAR <b>1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN. <b></b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.			
10 CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Electric Co.</b>	
13a STATE <b>Maryland</b>			13b COUNTY <b>Caroline</b>		13c CITY OR TOWN <b>Denton</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14 FATHER'S NAME FIRST <b>Walter</b> MIDDLE <b></b> LAST <b>Long</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Mattie</b> MIDDLE <b></b> LAST <b>Mattewes</b>			13e STREET ADDRESS / ZIP CODE <b>Williston Rd 21629</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. <b>216104524</b>		17 INFORMANT ADDRESS <b>Mrs. Margret Long, Denton, Md 21629</b>				
18 CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>arteriosclerotic coronary artery disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>10-15 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <b>Hypertension essential</b>									
19a. DATE OF OPERATION: <b>9/9</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Lawrence Bohan M.D.</b>						22c. DATE SIGNED <b>10-9-85</b>		22d. ADDRESS <b>Easton, Md. 21601</b>	
23a BURIAL, CREMATION, REMOVAL (STATE CITY) <b>Burial</b>			23b DATE <b>10/12/85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ridgely Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Ridgely Caroline MD</b>		
24 FUNERAL DIRECTOR NAME <b>Randolph P. Moore</b> ADDRESS <b>Denton, Md.</b>						25a. DATE REC'D. BY REGISTRAR <b>OCT 6 1985</b>			
25b. REGISTRAR'S SIGNATURE <b>John H. ...</b>									

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified above.



310069

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

12:05AM

1 DECEASED NAME (TYPE OR PRINT) <b>William Eugene Long</b>			2a DATE OF DEATH MONTH DAY YEAR <b>10 30 85</b>			2b HOUR <b>0005 A.M.</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>4 26 33</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Carolina</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD.			
10 CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Musician</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Entertainment</b>	
13a STATE <b>Maryland</b>				13b COUNTY <b>Caroline</b>		13c CITY OR TOWN <b>Preston</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Ireland B. Long</b>				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Percie C. Goan</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>245-46-8963</b>		17 INFORMANT ADDRESS <b>Charlotte L. Long see 13e.</b>					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Suspected Cardiac arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Diabetic Hypoglycemia</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b> <b>12 hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>Diabetic microvascular PERITONITIS</b>									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e PLACE OF INJURY (ATHOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>Louvenia D. Bogan MD</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED	
22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Louvenia D. Bogan MD</b>				22e ADDRESS <b>Easton, Md.</b>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b DATE <b>11-2-85</b>		23c NAME OF CEMETERY OR CREMATORY <b>Jr. Order Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Preston Caroline Md.</b>		
24 FUNERAL DIRECTOR NAME <b>Newman Funeral Home</b>				ADDRESS <b>Easton, Md.</b>		25a DATE REC'D. BY REGISTRAR <b>NOV 04 1985</b>		25b REGISTRAR'S SIGNATURE <b>W. W. W. W.</b>	

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 60M 7/84  
(VRA 15, 4)

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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 6 1 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <u>Guy W. Medford</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>10-1-85</u>		2b. HOUR <u>7:15</u> PM	
3 SEX <u>Male</u>		4 RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>Sept. 24, 1924</u>		6 AGE (IN YEARS LAST BIRTHDAY) <u>61</u> YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Hurlock, Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <u>Talbot</u> MD.
10. CITY OR TOWN OF DEATH <u>Easton</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Revermaria</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Supervisor - Continental Can Co.</u>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>Maryland</u>			13b. COUNTY <u>Dorchester</u>		13c. CITY OR TOWN <u>Hurlock</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>Nathaniel W. Medford</u>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Alda Wright</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>			16b. SOCIAL SECURITY NO. <u>194-18-4186</u>		17. INFORMANT ADDRESS <u>Rebecca Medford, Box 255, Hurlock, Md. 21643</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF <u>Cardiomyopathy</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARDIOMYOPATHY</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u> <u>4 mo</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <u>Squamous cell skin cancer with extensive metastases</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>MARCH 19 85</u> , to <u>1 OCT 19 85</u> that (I) (we) last saw the deceased alive on <u>1 OCT 19 85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (s) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>Stephen P. Carney</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>10-2-85</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Stephen P. Carney, M.D.</u>				22e. ADDRESS <u>Dutchman's Lane, Easton, Maryland 21601</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>Oct. 4, 1985</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Unity Washington Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Hurlock, Dorchester, Maryland</u>
24. FUNERAL DIRECTOR NAME <u>Frampton - Houbins Box 43 Federalby, Md 21632</u>				25. DATE RECEIVED BY REGISTRAR <u>OCT 7 1985</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other final disposition of the body.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified of this.

BP

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Constitutional Health Institute

Cardiology and W

Constitutional Health Institute

Constitutional Health Institute

Constitutional Health Institute

Constitutional Health Institute



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

1- FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Mary <del>XXXX</del> Michie		2a DATE OF DEATH MONTH DAY YEAR 10/15/85		2b HOUR 8:00AM	
3 SEX female		4 RACE caucasian		5 DATE OF BIRTH MONTH DAY YEAR July 9 1902		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Indiana		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD.	
10 CITY OR TOWN OF DEATH Easton, Md.		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 820 N. Washin gton St., Easton		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Social Worker		12b KIND OF BUSINESS OR INDUSTRY State Gov't	
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Talbot		13c. CITY OR TOWN Easton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST Jesse Horace Barlow		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alma Thompson		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b SOCIAL SECURITY NO. 202-01-0030		17 INFORMANT ADDRESS Bernice B. Gallozzi Box 254 Tilghman, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Chronic Congestive Failure</u> <u>Diabetes Mellitus</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>9/26</u> 19 <u>85</u> to <u>10/15</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>9/26</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE <u>W. H. Wood, Jr.</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 10/15/85	
22d PHYSICIAN'S NAME (TYPE OR PRINT) William H. Wood, Jr., M.D.		22e ADDRESS Rt. 3, Box 106, Easton, Maryland 21601					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) cremation		23b DATE 10-16-85		23c NAME OF CEMETERY OR CREMATORY Delmarva Crematory		23d LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del.	
24 FUNERAL DIRECTOR NAME Nnam Funeral Home				ADDRESS Easton, Md.		25a DATE REC'D. BY REGISTRAR OCT 17 1985	
		25b REGISTRAR'S SIGNATURE <u>Jane Davidson-Hendall</u>					

MEDICAL CERTIFICATION

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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE-MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified by office.

BP



CS-1010A

WMB WATZ/HV

95871 NOT DO 8005

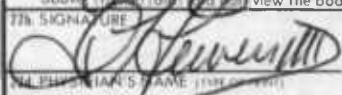
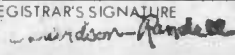
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FOR  
1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

5 29617

1 DECEASED NAME (TYPE OR PRINT) <b>William Irving Miller</b>			2a DATE OF DEATH MONTH DAY YEAR <b>10 30 85</b>		2b HOUR <b>4 19 P.M.</b>
3 SEX <b>male</b>	4 RACE <b>caucasian</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>7 7 02</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>83</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>	7b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.	
10 CITY OR TOWN OF DEATH <b>EASTON</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Easton Memorial Hosp.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Professor</b>	12b KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
13a STATE <b>Maryland</b>			13b COUNTY <b>Talbot</b>	13c CITY OR TOWN <b>Easton</b>	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Elmer Miller</b>			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amellia Brandt</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b SOCIAL SECURITY NO. <b>191-26-4287</b>		17. INFORMANT ADDRESS <b>Majel Brooks Miller see 13e.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>AS CVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>49 Hrs</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10/28 95</b>	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (1) (this hospital) attended the deceased from <b>10/28 95</b> to <b>10/30 95</b> , that (1) (we) last saw the deceased alive <b>10/30 95</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (1) (we) view the body after death.					
22b SIGNATURE 		DEGREE <b>D.T. Lewers, M.D.</b>		22c DATE SIGNED <b>10/31/95</b>	
22d PHYSICIAN'S NAME (TYPE OR PRINT)		22e ADDRESS <b>Easton, Md.</b>			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>	23b DATE <b>10-31-85</b>	23c NAME OF CEMETERY OR CREMATORY <b>Delmarva Crematory</b>	23d LOCATION CITY OR TOWN COUNTY STATE <b>Lewes Sussex De.</b>	25a DATE REC'D. BY REGISTRAR <b>NOV 04 1985</b>	
24 FUNERAL DIRECTOR NAME ADDRESS <b>Newnam Funeral Home Easton, Md.</b>			25b REGISTRAR'S SIGNATURE 		



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

29618

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Weldon Murray			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 11 19 85			2b. HOUR M			
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 08 15 53	6. AGE (IN YEARS LAST BIRTHDAY) 32 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 11 19 85			2d. HOUR 7:15A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Talbot County MD.			
10. CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY G.A.		13c. CITY OR TOWN Queen Anne		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS Box 80A 21657			
14. FATHER'S NAME FIRST MIDDLE LAST Louis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Jacobs						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) N/A		(IF YES, GIVE WAR OR DATES) N/A		16b. SOCIAL SECURITY NO. 21460-9368		17. INFORMANT Marry Murray ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Thomas D. Smith</u>			TITLE (SPECIFY) M.D. Acting Chief			DATE SIGNED 10/12/85			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto. MD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/16/85		23c. NAME OF CEMETERY OR CREMATORY Sandtown		23d. LOCATION Hillbroke Gs MD.		
24. FUNERAL DIRECTOR NAME George H. Pishel			ADDRESS Easton MD.		25a. DATE REC'D BY REGISTRAR OCT 22 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendell		

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

07/84  
25MBP 136/1  
DHMH - 17  
(VR A15 ME (5))

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSFERMENT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

2027 COTTON FIBER

DMDB MIAFZIHQ



2027 COTTON FIBER

305130

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1- FOR STATE REGISTRAR		REG. NO. 5 29619									
1 DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Virginia L. Perkins								10-17-85		3 <sup>15</sup> PM	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		Negro		June 18, 1928		57 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Buckley, Va.		U.S.A.				Talbot MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Easton		Memorial Hospital						Food Processor		Canning	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE					
Maryland		Dorchester		Hurlock		Rt. 1, Box 132		21643			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Thomas Perkins		Katie Holley Lake									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		21643			
No		218-20-9457		Vanessa Perkins, PO Box 901, Hurlock, Md.							
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Metastatic Cancer to Stomach and Liver											
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the Pancreas										10 mos	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10/11/85 to 10/17/85, that (I) (we) last saw the deceased alive on 10/17/85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22d. DATE SIGNED			
Wm H Wood		MD						10/18/85			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
Wm H Wood		EASTON Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Oct. 22, 1985		Federal Hill Cemetery		Federalsburg, Caroline, Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
FRAMPTON-HAWKINS		Box 43		OCT 28 1985		John Davidson					

Virginia L. Perkins

Tell

Eastern Memorial Hospital



Franklin D. Roosevelt



312019

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 6 2 0

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William Wrightson PERRY</b> <i>William Perry</i>		2a. DATE OF DEATH MONTH DAY YEAR <b>10 27 85</b>		2b. HOUR <b>4 48 PM</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>April 22, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Easton Memorial Hospital</b>		12a. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot County</b> MD.	
10. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Queen Anne's</b>		13c. CITY OR TOWN <b>Grasonville</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John McFeely Perry</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace Emily Meakin</b>		16. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Owner-Operator (Ret.)</b>	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		17b. SOCIAL SECURITY NO. <b>212-10-5813</b>		17c. INFORMANT <b>Wife</b> ADDRESS <b>R.D. 2, Box 516</b>	
18. FATHER'S NAME FIRST MIDDLE LAST <b>John McFeely Perry</b>		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Grace Emily Meakin</b>		20. STREET ADDRESS / ZIP CODE <b>R.D. 2, Box 516, 21638</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>HYPOTENSION</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>HEART FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 HOURS</b> <b>4 DAYS</b>
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Organic brain disease, pneumonia, diabetes, sepsis.**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/23/85</b> , 19____, to <b>10/27/85</b> , 19____, that (I) (we) last saw the deceased alive on <b>10/27/85</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>C. W. Barton</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/28/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>C. W. Barton</b>		22e. ADDRESS <b>Easton, Md. 21601</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Oct. 30, 1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Centreville, Q.A.Co., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>James H. Barton, Jr.</b> <b>Barton Funeral Home</b>		25a. DATE REC'D. BY REGISTRAR <b>10/24/85</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

BP

H

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. These places should be removed from the certificate and placed in the file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

312013

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



Table 1

301061

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 6 2 1

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Gladys E. Persinger</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 21 85</b>		2b. HOUR <b>10<sup>56</sup> PM</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>5 9 1908</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR TERRITORY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Easton</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Easton Memorial</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Tin Mill Worker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Easton</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Robert Thompson</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene Manning</b>		13e. STREET ADDRESS / ZIP CODE <b>8 Albon Ct.-Hyde Park Traylor Ct. 21601</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>215-22-6036</b>		17. INFORMANT <b>Jack Persinger</b> ADDRESS <b>Same as 13e</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Pancreas</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ASCVD = coronary artery disease</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>11/21</b> 19 <b>80</b> to <b>10/21</b> 19 <b>85</b> , that (1) (we) last saw the deceased alive on <b>10/15</b> 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did not view the body after death.					
22b. SIGNATURE <b>William J. Banfield</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>William J. Banfield, M.D.</b>		22e. ADDRESS <b>505 Dutchmans Lane, Easton, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>10/25/1985</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gardens Of Faith</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Duda-Ruck, Inc.</b>		ADDRESS <b>7922 Wise Avenue Dundalk, Maryland 21222</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 24 1985</b>	
25b. REGISTRAR'S SIGNATURE					

MEDICAL CERTIFICATION

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed and filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies of pages 1 and 2 and file them with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or other qualified person should be consulted.

SECTION 5

10/11/1941



Arrived at ...

Accused ...



...

...

289171

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 5 2 9 6 2 2

REG. NO.

1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Dorothy DAVIS Reese</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>10 8 85</b>		2b. HOUR <b>9:52 PM</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 22 12</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>73</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot County MD</b>	
10. CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Easton Memorial</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Exec. Sec.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>General Motors</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>		13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Oxford</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter F. Davis</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah M. Robertson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-12-1741</b>	
17. INFORMANT ADDRESS <b>P.O. Box 724</b>		18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease with</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac Arrhythmia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>COPD</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE <b>STREET</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>10/8 1983</b> , to <b>10/8 85</b> , that (I) (we) last saw the deceased alive on <b>10/8 85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Wm H Wood Jr MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10/9/85</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>WMH Wood</b>		22e. ADDRESS <b>EASTON Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>cremation</b>		23b. DATE <b>10-9-85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salisbury Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Salisbury Wic. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Newnam Funeral Home</b>		ADDRESS <b>Easton, Md. 21601</b>		25a. DATE REC'D. BY REGISTRAR <b>OCT 14 1985</b>		25b. REGISTRAR'S SIGNATURE <b>Sue Davidson-Randall</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

17283



295009

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 5 2 9 6 2 3

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME FIRST MIDDLE LAST WILLIAM Neale Rodger			2a DATE OF DEATH MONTH DAY YEAR 10-7-85		2b HOUR 12 <sup>00</sup> M	
3 SEX Male		4 RACE Cau.		5 DATE OF BIRTH MONTH DAY YEAR Dec 26, 1902		
6 AGE (IN YEARS LAST BIRTHDAY) 82 YRS		7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b CITIZEN OF WHAT COUNTRY? USA		
8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Talbot MD				
10 CITY OR TOWN OF DEATH Easton		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Memorial Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Str. Engineer		
12b KIND OF BUSINESS OR INDUSTRY Steel		13a STATE Maryland				
13b COUNTY Talbot		13c CITY OR TOWN St. Michaels		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e STREET ADDRESS / ZIP CODE 21663		14 FATHER'S NAME FIRST MIDDLE LAST Charles Hollis Rodger				
15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST May Yeomans		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				
16b SOCIAL SECURITY NO. 090-07-6801		17 INFORMANT ADDRESS Alice E. Rodger Rio Vista St. Michaels, Md. 21663				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>AS AHS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced Dementia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Advanced Dementia</u>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>	
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from <u>10/5</u> , 19 <u>85</u> , to <u>10/7</u> , 19 <u>85</u> that (I) (we) last saw the deceased alive on <u>10/7</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE Wm H Wood		DEGREE MD		22c DATE SIGNED 10/7/85		
22d PHYSICIAN'S NAME (TYPE OR PRINT) Wm H Wood		22e ADDRESS EASTON MD				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b DATE Oct 8, 1985		23c NAME OF CEMETERY OR CREMATORY Lee Crematorium		
23d LOCATION CITY OR TOWN Washington, D. C.		23e STATE D. C.				
24 FUNERAL DIRECTOR NAME Sharon E. Leavelle		ADDRESS St. Michaels, Md		25a DATE REC'D. BY REGISTRAR OCT 14 1985		
25b REGISTRAR'S SIGNATURE John E. Leavelle						

MEDICAL CERTIFICATION

BP

DHMH - 16 60M 7/84  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with great care after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and is complete, it is to be filed by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201



305063

Male

Age

Dec 22, 1904

On

New York

Age

Mr. Benjamin Steel

1904

Age

St. Michael's

Trinity

Maryland

Charles H. H. Rogers

By Thomas

His wife

000-07-0801 Alice E. Rogers St. Michael's, Md.

No

Transmission Oct 2, 1905 Los Angeles Washington, D. C.

296181

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ETHEL VALLIANT SHANNAHAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>OCT 14 85</b>			2b. HOUR MIN. <b>4 15</b> M				
3 SEX <b>FEMALE</b>		4 RACE <b>CAUC.</b>		5. DATE OF BIRTH DAY MONTH YEAR <b>NOV. 5, 1887</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 1 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>TALBOT</b> MD.				
10. CITY OR TOWN OF DEATH <b>EASTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>MERIDIAN MERIDIAN THE PINES</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>TALBOT</b>		13c. CITY OR TOWN <b>ST. MICHAELS</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>CHERRY ST. 21663</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN VALLIANT</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ESTHER MOLYNEAUX</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>215-07-3869</b>		17. INFORMANT ADDRESS <b>ST. MICHAELS, NORMAN M. SHANNAHAN JR. MARYLAND 21663</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO: <i>Chronic Hypertension, Coronary Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) DUE TO: OR AS A CONSEQUENCE OF (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>Diabetic Mellitus</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>10-10-85</i> to <i>10-14-85</i> , that (I) (we) last saw the deceased alive on <i>10-12-85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I/we did not view the body after death, so state.)										
22b. SIGNATURE <i>R. Lane Wroth, M.D.</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>10-14-85</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. LANE WROTH M.D.</b>			22e. ADDRESS <b>ST. MICHAELS, MARYLAND 21663</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>OCT. 16, 85</b>		23c. NAME OF CEMETERY OR CREMATORY <b>SPRING HILL CEM.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>EASTON TALBOT MARYLAND</b>			
24. FUNERAL DIRECTOR NAME <i>Samson E. Leonard</i>						25a. DATE REC'D. BY REGISTRAR <b>OCT 21 1985</b>				
25b. REGISTRAR'S SIGNATURE <i>John Davidson-Rodgers</i>										

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificate pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1- STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 5 2 9 6 2 5

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) <i>Helen P. Speerl</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10-14-85</i>			2b. HOUR MIN. <i>1:30 P</i>			
3 SEX <i>Female</i>		4 RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>November 28, 1901</i>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>83</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Philadelphia, Pa.</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Talbot</i> MD.			
10 CITY OR TOWN OF DEATH <i>Easton</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Memorial Hospital at Easton</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>DuPont Co.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Nylon Production</i>	
13a. STATE <i>Maryland</i>				13b. CITY OR TOWN <i>Federalburg</i>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE <i>107 Liberty Road 21632</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Howard J. Phillips</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lena Watkins</i>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>216-05-3053</i>		17 INFORMANT ADDRESS <i>Mary V. Thomas, 2993 Yorkway, Baltimore, Md. 21222</i>					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) *ventricular arrhythmia*

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last(b) *ischemic cardiomyopathy*

DUE TO, OR AS A CONSEQUENCE OF

(c) *atherosclerotic cardiovascular disease*APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>10-3</i> , 19 <i>85</i> , to <i>10-14</i> , 19 <i>85</i> , that (I) (we) last saw the deceased alive on <i>10-14</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>R. B. Sanchez</i>				DEGREE <i>MD</i>		22c. DATE SIGNED <i>10/14/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>R. B. Sanchez</i>				22e. ADDRESS			

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b DATE <i>Oct. 17, 1985</i>		23c. NAME OF CEMETERY OR CREMATORY <i>East New Market Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>E. New Market, Dorchester, Md.</i>	
24 FUNERAL DIRECTOR NAME <i>FRAMPTON-HAWKINS - FEDERALBURG</i>				ADDRESS <i>Box 43</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 17 1985</i>	
				25b. REGISTRAR'S SIGNATURE <i>John R. Riddle</i>			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Bennie W. Sudler</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>October 10 1985</b>			2b. HOUR <b>4:30</b> AM				
3. SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 16 92</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		9. CITIZEN OF WHAT COUNTRY? <b>USA</b>		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot</b> MD				
12. CITY OR TOWN OF DEATH <b>EASTON</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Memorial Hospital</b>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer</b>		15. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE <b>Maryland</b>			16b. COUNTY <b>Caroline</b>		16c. CITY OR TOWN <b>Greensboro</b>		16d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		16e. STREET ADDRESS / ZIP CODE <b>Maple Ave. 21639</b>	
17. FATHER'S NAME FIRST MIDDLE LAST <b>John W. Sudler</b>			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Kate ?</b>							
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			20. SOCIAL SECURITY NO. <b>220-32-8651</b>		21. INFORMANT <b>Mildred Crocker</b>				22. ADDRESS <b>Ridgely, MD</b>	
23. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Probable Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Urthia Stature</b>										
24. DATE OF OPERATION <b>9/6/85</b>			25. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>9/6/85</b>			26. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			33. LOCATION STREET CITY OR TOWN COUNTY STATE				
34. I certify that (I) (this hospital) attended the deceased from <b>9/6/85</b> to <b>10/10/85</b> , that (I) (we) last saw the deceased on <b>10/10/85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
35. SIGNATURE <b>D.T. Lewers</b>						36. DEGREE <b>M.D.</b>		37. DATE SIGNED <b>10/10/85</b>		
38. PHYSICIAN'S BLOCK (TYPE OR PRINT) <b>D.T. Lewers, M.D.</b>						39. ADDRESS <b>Easton, MD 21601</b>				
40. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			41. DATE <b>10-14-85</b>		42. NAME OF CEMETERY OR CREMATORY <b>Cokers Cemetery</b>		43. LOCATION CITY OR TOWN COUNTY STATE <b>Greensboro CA MD</b>			
44. FUNERAL DIRECTOR NAME <b>John E. Boulais</b>						45. ADDRESS <b>Greensboro, MD</b>		46. DATE REC'D. BY REGISTRAR <b>OCT 12 1985</b>		
						47. REGISTRAR'S SIGNATURE <b>John E. Boulais</b>				

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please forward to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other significant event, the medical examiner must be notified at once.

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MAY 19 1964

Probable myocardial infarction  
recd

Norton, MD 21601

D.T. Lavery, MD



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DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL. TRANSIT PERMIT PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))

 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

 29627  
REG. NO.

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH ESTIMATED										3. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE KNOWN OF DEATH ESTIMATED										3. HOUR	
FIRST		MIDDLE		LAST		MONTH		DAY		YEAR		HOUR	
William R. Vrba						10		20		1985		4:50	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	9. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	Cauca.	Apr 18, 1914	71 YRS.			10-20-85						4:50	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
New York	U. S. A.				Tallbot								
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
Easton	Memorial		Mechanic		Mechanic								
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
Maryland		Caroline		Denton		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Anthony Mill Road 21629					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. ADDRESS									
Jan		Barbara		Sedlak									
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		17b. SOCIAL SECURITY NO.		17. INFORMANT									
Yes		WW II		Mrs. Bertha Winters, Denton, MD									
18. CAUSE OF DEATH (Enter only one cause per (a), (b), and (c).)													
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a)													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC)				21f. LOCATION					
								STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from													
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE				M.D.				MEDICAL EXAMINER				DATE SIGNED	
R. Lane Wroth				Deputy								10-21-85	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
R. Lane Wroth, M. D.				St. Michaels, Maryland									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION	
Burial				10/24/85				Md Eastern Shore Vet. Cem.				Beulah Dorchester	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Morte Funeral Home, PA. 1262nd St Denton Md				OCT 24 1985				John Wroth					

304312



*[Faint, illegible text and markings are visible across the page, including what appears to be a large, stylized signature or stamp in the center.]*

294047

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

3 5 2 9 6 2 8

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Oleada G. Whitely			2a DATE OF DEATH MONTH DAY YEAR 10 12 85			2b HOUR 11 1/2 AM			
3 SEX female		4 RACE caucasian		5. DATE OF BIRTH MONTH DAY YEAR 3 28 19		6 AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH TALBOT MD.			
10 CITY OR TOWN OF DEATH Easton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Easton Memorial Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b KIND OF BUSINESS OR INDUSTRY Auto Dealer	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Maryland		13b COUNTY Talbot		13c CITY OR TOWN Easton		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 221 Wye Ave., /21601	
14 FATHER'S NAME FIRST MIDDLE LAST Christian Gernert					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Higdon				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-05-3692		17 INFORMANT ADDRESS Vernon R. Whitely see 13e.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF ASCD (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Diabetes mellitus									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (1) this hospital attended the deceased from 10/12/85 to 10/12/85, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not view the body after death.)									
22b SIGNATURE Donald Lewers, M.D.				22c. DATE SIGNED 10/14/85					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-15-85		23c. NAME OF CEMETERY OR CREMATORY Belmont Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Choptank Caroline Md.	
24 FUNERAL DIRECTOR NAME Newnam Funeral Home						25a DATE REC'D BY REGISTRAR 10/17/85			
ADDRESS Easton, Md. 21601						25b REGISTRAR'S SIGNATURE J. H. HARRIS			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, and it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Rebate for 1st quarter 1961

Rebate for 2nd quarter 1961

Rebate for 3rd quarter 1961

Rebate for 4th quarter 1961

Rebate for 1st quarter 1962

296103

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 5 2 9 6 2 9

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) <b>Roberta Jones Wise</b>			2a DATE OF DEATH MONTH DAY YEAR <b>10 9 85</b>		2b HOUR <b>5:52 P.M.</b>	
3 SEX <b>Female</b>		4 RACE <b>Black</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>Oct. 5, 1916</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Preston, Md.</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Talbot County</b> MD.
10 CITY OR TOWN OF DEATH <b>Easton</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Easton Memorial</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Domestic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Homes</b>
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <b>Maryland</b>			13b COUNTY <b>Caroline</b>		13c CITY OR TOWN <b>Federalburg</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Albert Jones</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alberta Strawberry</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>
16b SOCIAL SECURITY NO. <b>219-05-6839</b>			17 INFORMANT ADDRESS <b>21643</b> <b>Bernice Jones, Rt. 1, Box 120A, Hurlock, Md.</b>			

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**days****years**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1

MEDICAL CERTIFICATION

19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>10 - 6 19 85</b>		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>Cerebrovascular Accident</b>			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>Hypertension</b>		21f LOCATION STREET CITY OR TOWN COUNTY STATE <b>Easton, Md. 21601</b>			
22a I certify that (I) (this hospital) attended the deceased from <b>10-6</b> , 19 <b>85</b> , to <b>10-9</b> , 19 <b>85</b> that (I) (we) last saw the deceased alive on <b>10-8</b> , 19 <b>85</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b SIGNATURE <b>Thomas Fauntleroy</b>		DEGREE <b>M.D.</b>		22c DATE SIGNED <b>10-15-85</b>		22d PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas Fauntleroy, M.D.</b>	
		22e ADDRESS <b>Easton, Md. 21601</b>					

23a BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b DATE <b>Oct. 12, 1985</b>		23c NAME OF CEMETERY OR CREMATORY <b>Coppins AME Cemetery</b>		23d LOCATION CITY OR TOWN COUNTY STATE <b>Preston, Caroline, Maryland</b>	
24 FUNERAL DIRECTOR NAME <b>Franklin Hawkins</b>				ADDRESS <b>Box 43 Federalburg, Md</b>		25a DATE REC'D. BY REGISTRAR <b>OCT 18 1985</b>	
				25b REGISTRAR'S SIGNATURE <b>John Harrison</b>			

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